		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042671

Facility Name: PRAIRIE VILLAGE HEALTHCARE CENTER

Address: 1024 W. WALNUT (Number) JACKSONVILLE (City) 62650 (Zip Code)

County: MORGAN

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-4149930

Date of Initial License for Current Owners: 05/01/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	74	Skilled (SNF)	74	27,084	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	19,032	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	46,116	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	95		4,240	4,335	8
9	SNF/PED					9
10	ICF	24,951	3,369		28,320	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,046	3,369	4,240	32,655	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.81%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 4,240

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENT # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	125,075	10,129	8,990	144,194		144,194		144,194			1
2	Food Purchase		116,530		116,530	(11,749)	104,781	(479)	104,302			2
3	Housekeeping	79,393	22,923		102,316		102,316		102,316			3
4	Laundry	36,015	11,502	154	47,671		47,671		47,671			4
5	Heat and Other Utilities			91,262	91,262		91,262	452	91,714			5
6	Maintenance	28,237	46,481	17,118	91,836		91,836	4,609	96,445			6
7	Other (specify):*			9,666	9,666		9,666	237	9,903			7
8	**TOTAL General Services**	268,720	207,565	127,190	603,475	(11,749)	591,726	4,819	596,545			8
	B. Health Care and Programs											
9	Medical Director			27,400	27,400		27,400		27,400			9
10	Nursing and Medical Records	830,232	83,168	160,486	1,073,886		1,073,886	(132,604)	941,282			10
10a	Therapy	170,812	5,534	81,740	258,086		258,086	(71,878)	186,208			10a
11	Activities	31,684	87		31,771		31,771		31,771			11
12	Social Services	19,318			19,318		19,318		19,318			12
13	Nurse Aide Training											13
14	Program Transportation			1,927	1,927		1,927		1,927			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,052,046	88,789	271,553	1,412,388		1,412,388	(204,482)	1,207,906			16
	C. General Administration											
17	Administrative	97,380			97,380		97,380	46,636	144,016			17
18	Directors Fees											18
19	Professional Services			303,273	303,273		303,273	(137,423)	165,850			19
20	Dues, Fees, Subscriptions & Promotions			32,731	32,731		32,731	(21,026)	11,705			20
21	Clerical & General Office Expenses	113,183	10,846	107,494	231,523		231,523	(59,842)	171,681			21
22	Employee Benefits & Payroll Taxes			203,610	203,610	11,749	215,359		215,359			22
23	Inservice Training & Education			4,473	4,473		4,473	837	5,310			23
24	Travel and Seminar			589	589		589	275	864			24
25	Other Admin. Staff Transportation			3,759	3,759		3,759	2,779	6,538			25
26	Insurance-Prop.Liab.Malpractice			85,653	85,653		85,653	1,749	87,402			26
27	Other (specify):*							30,829	30,829			27
28	**TOTAL General Administration**	210,563	10,846	741,582	962,991	11,749	974,740	(135,186)	839,554			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,531,329	307,200	1,140,325	2,978,854		2,978,854	(334,849)	2,644,005			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: PRAIRIE VILLAGE HEALTHCARE CENTER #0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,355	
	REPAIRS & MAINTENANCE		635	
			0	8,990
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		154	
			0	154
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		36,260	
	ELECTRICITY		34,033	
	WATER		15,383	
	CABLE TV - LOBBY		5,586	
			0	91,262
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,128	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,447	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,010	
	FIRE SERVICE		2,533	
			0	
			0	
			0	17,118
7	**OTHER**			
	SCAVENGER		9,666	
	SECURITY SERVICE		0	9,666
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	27,400	27,400

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B 46-2	4,108	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	669	
	PHARMACY CONSULTANT	XVIII B 39-2	709	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS		0	
	PSYCHIATRIC	XVIII B 47-2	5,000	
	RN CONSULTANT	XVIII B 38-2	0	
	MEDICARE & PUBLIC AID CONSULTANT	XVIII B 48-2	150,000	
			0	160,486
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		5,453	
	SPEECH THERAPY SERVICES		3,794	
	OCCUPATIONAL THERAPY SERVICES		4,993	
	THERAPY CONTRACT SERVICES		56,700	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,400	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	81,740
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER #0042671 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,927	1,927
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	21,131	
	ADMINISTRATIVE CONSULTANTS	XIX C	238,000	
	PROFESSIONAL FEES	XIX C	44,142	
			0	303,273
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	22,668	
	EMPLOYEE WANT ADS	XIX F	8,397	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	211	
	LICENSES & PERMITS	XIX F	1,055	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	350	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	50	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	32,731
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		26	
	EQUIPMENT REPAIR & MAINTENANCE		3,193	
	OUTSIDE CLERICAL SERVICES		75,600	
	PENALTIES / OVERDRAFT CHARGES	VI 18	17,938	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		9,772	
	MESSENGER SERVICE		965	
			0	107,494

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	116,269	
	UNEMPLOYMENT COMPENSATION	XIX D	25,964	
	WORKERS COMPENSATION INSURANCI	XIX D	37,170	
	HOSPITALIZATION INSURANCE	XIX D	21,660	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,342	
	EMPLOYEE PHYSICAL EXAMS	XIX D	205	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	203,610
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,473	4,473
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	589	
			0	
			0	589
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		3,759	3,759
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		85,653	85,653
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,140,325

PRAIRIE VILLAGE HEALTHCARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	116,530	PATIENT MEALS	97965
LESS SALES TAX	(479)	ADD EMPLOYEE MEALS	10980
NET FOOD	116,051	TOTAL MEALS/YEAR	108945
TOTAL PATIENT CENSUS	32,655	NET FOOD	116051
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	108945
TOTAL PATIENT MEALS	97965	COST PER MEAL	1.07
		TIME EMPLOYEE MEALS	10980
ADD # EMPLOYEE MEALS/DAY	30		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	11749
TOTAL EMPLOYEE MEALS	10980		

PRAIRIE VILLAGE HEALTHCARE CENTER
TRANSPORTATION - STAFF
12/31/04 **G/L #18370**

DATE	ALLYSON KUEKER	DEBORAH WEDER	BOB RIDDINGS	DIANA BLACKKETTER	BAKST	SECRETARY OF STATE	SUSAN MAMLOCK	TOTAL
JAN				117.07				117.07
FEB	62.62			69.83				132.45
MAR		55.00		286.48				341.48
APR				55.48				55.48
MAY				228.83				228.83
JUN	145.00			197.78				342.78
JUL				82.01				82.01
AUG	149.10		115.60	322.67		78.00		665.37
SEP				92.75				92.75
OCT	194.31			113.21			147.09	454.61
NOV				283.92	478.49		173.71	936.12
DEC				121.90			143.75	265.65
TOTAL	551.03	55.00	115.60	1,971.93	478.49	78.00	464.55	3,714.60

GASOLINE FOR FACILITY BANKING, MAINTENANCE, MARKETING, AND ACTIVITIES

PRAIRIE VILLAGE HEALTHCARE CENTER
EDUCATION & SEMINAR
12/31/04

DATE	INV	SPONSOR OF SEMINAR	PURPOSE OF SEMINAR	PERSONNEL ATTENDING	LOC	COST OF SEMINAR
1.04	X	LINCOLNLAND COMMUNITY COLLEGE	TEXTBOOK FOR CNA CLASS	LESLIE CHANEY	IL	53.63
1.04	X	LINCOLNLAND COMMUNITY COLLEGE	CNA CLASS	LESLIE CHANEY	IL	315.00
2.04	X	IL HEALTHCARE ASSOCIATION	NURSING HOME ADMINISTRATION EXAM - REVIEW COURSE	PAM BROWN	IL	325.00
2.04	X	IL HEALTHCARE ASSOCIATION	NEW ENFORCEMENT OF SUBPART S	ALLYSON KUEKER	IL	60.00
				DENISE ARNOLD	IL	60.00
5.04	X	LINCOLNLAND COMMUNITY COLLEGE	BASIC NURSE ASST. TRAINING CLASS	DANIELLE N. JONES	IL	315.00
5.04	X	LINCOLNLAND COMMUNITY COLLEGE	BASIC NURSE ASST. TRAINING CLASS	ILEEN M. SIX	IL	315.00
5.04	X	LINCOLNLAND COMMUNITY COLLEGE	BASIC NURSE ASST. TRAINING CLASS	PHILLIP KOPPELMAN	IL	315.00
6.04	X	PAM BROWN	REIMBURSEMENT FOR STATE & FED ADMIN TESTS	PAM BROWN	IL	469.00
6.04	X	LINCOLNLAND COMMUNITY COLLEGE	BASIC NURSE ASST. TRAINING CLASS	SHAREE WOOD	IL	315.00
6.04	X	LINCOLNLAND COMMUNITY COLLEGE	TEXTBOOK FOR CNA CLASS	SHAREE WOOD	IL	56.84
6.04	X	LINCOLNLAND COMMUNITY COLLEGE	TEXTBOOK FOR CNA CLASS	DANIELLE N. JONES	IL	56.84
6.04	X	LINCOLNLAND COMMUNITY COLLEGE	TEXTBOOK FOR CNA CLASS	ILEEN M. SIX	IL	56.84
6.04	X	LINCOLNLAND COMMUNITY COLLEGE	TEXTBOOK FOR CNA CLASS	PHILLIP KOPPELMAN	IL	56.84
7.04	X	NFPA INTERNATIONAL	LIFE SAFETY CODE BOOK		IL	226.85
10.04	X	LIPPINCOTT WILLIAMS & WILKINS	BOOKS	ALLYSON KUEKER	IL	176.52
11.04	X	FRED C. BOCH BCD	UNDERSTANDING NEW IDPA REIMBURSEMENT PROGRAM	LISA DAVIS	IL	119.00
				JENNIFER RIANGS	IL	119.00
				SHERI GOODALL	IL	119.00
				TERI SOLOMAN	IL	119.00
11.04	X	KTG LABOR CONSULTANTS	WAGE AND HOUR SEMINAR	DIANA BLACKKETTER	IL	60.00
				PAM BROWN	IL	85.00
11.04	X	PASSAVANT MEMORIAL HOSPITAL	CPR CARDS		IL	30.00
12.04	X	ENLOE INFUSION SERVICES	IV CERTIFICATION	AMY STRUBBE	IL	150.00
				RITA MOORE	IL	150.00
				SHEILA LEWIS	IL	150.00
				TAMMY HAMMEIS	IL	150.00
12.04	X	LIPPINCOTT WILLIAMS & WILK	BOOKS	ALLYSON KUEKER	IL	48.40
						4,472.76

PRAIRIE VILLAGE HEALTHCARE CENTER
EQUIPMENT RENTAL
12/31/04

VENDOR	DESCRIPTION	AMOUNT
UNIVERSAL HOSPITAL SERVICES	NURSING EQUIPMENT	835
RCS MANAGEMENT	NURSING EQUIPMENT	3,706
DON STEINKUHLER	PLANT EQUIPMENT	75
FLYNN SALES & SERV	LAUNDRY EQUIPMENT	7,500
QUALITY WATER SERIVCE FINANCE	PLANT EQUIPMENT	483
CDS OFFICE TECHNOLOGY	COPIER	2,204
GE CAPITAL	COPIER	1,669
		16,472
CAREPLUS REHAB	EQUIPMENT LEASE	52,356
		68,828

PRAIRIE VILLAGE HEALTHCARE CENTER
PROFESSIONAL FEES
12/31/04

VENDOR	DESCRIPTION	AMOUNT
CARE PLUS	DATA PROCESSING	$ 12,000
ACHIEVE	DATA PROCESSING	3,168
NATIONAL DATACARE	DATA PROCESSING	1,915
E-HEALTH DATA	DATA PROCESSING	857
AMERICAN DATA	DATA PROCESSING	3,191
CARE PLUS	ADMINISTRATIVE CONSULT	238,000
KBKB	ACCOUNTING	31,050
MEYER MAGENCE	LEGAL	3,604
MYERS MILLER	LEGAL	367
SACHNOFF & WEAVER	LEGAL	360
RICHARD PEELO	MEDICARE CONSULTANT	4,800
PERSONNEL PLANNERS	UC CONSULTANT	3,961
	TOTAL:	303,273

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER #0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			17,538	17,538		17,538	60,224	77,762			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,548	1,548		1,548	211,823	213,371			32
33	Real Estate Taxes			23,987	23,987		23,987		23,987			33
34	Rent-Facility & Grounds			245,666	245,666		245,666	(241,550)	4,116			34
35	Rent-Equipment & Vehicles			75,517	75,517		75,517	(47,890)	27,627			35
36	Other (specify):*											36
37	**TOTAL Ownership**			364,256	364,256		364,256	(17,393)	346,863			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		147,702	180,282	327,984		327,984	(150,787)	177,197			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,174	69,174		69,174		69,174			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		147,702	249,456	397,158		397,158	(150,787)	246,371			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,531,329	454,902	1,754,037	3,740,268		3,740,268	(503,029)	3,237,239			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,626)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(479)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(350)	20		17
18	Fines and Penalties	(17,938)	21		18
19	Entertainment		20		19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(22,668)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(36,224)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (79,335)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(423,694)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (423,694)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (503,029)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PRAIRIE VILLAGE HEALTHCARE CENTER

ID# 0042671

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ -36224	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(36,224)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(479)	0	0	0	0	0	0	0	0	0	0	(479)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	452	0	0	0	0	0	0	0	0	0	452	5
6	Maintenance	0	4,609	0	0	0	0	0	0	0	0	0	4,609	6
7	Other (specify):*	0	237	0	0	0	0	0	0	0	0	0	237	7
8	**TOTAL General Services**	(479)	5,298	0	0	0	0	0	0	0	0	0	4,819	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(132,604)	0	0	0	0	0	0	0	0	0	(132,604)	10
10a	Therapy	0	2,298	(74,176)	0	0	0	0	0	0	0	0	(71,878)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(130,306)	(74,176)	0	0	0	0	0	0	0	0	(204,482)	16
	C. General Administration													
17	Administrative	0	46,636	0	0	0	0	0	0	0	0	0	46,636	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(140,000)	2,577	0	0	0	0	0	0	0	0	(137,423)	19
20	Fees, Subscriptions & Promotions	(23,068)	0	2,042	0	0	0	0	0	0	0	0	(21,026)	20
21	Clerical & General Office Expenses	(54,162)	(75,600)	69,920	0	0	0	0	0	0	0	0	(59,842)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	837	0	0	0	0	0	0	0	0	837	23
24	Travel and Seminar	0	0	275	0	0	0	0	0	0	0	0	275	24
25	Other Admin. Staff Transportation	0	0	2,779	0	0	0	0	0	0	0	0	2,779	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,749	0	0	0	0	0	0	0	0	1,749	26
27	Other (specify):*	0	0	30,829	0	0	0	0	0	0	0	0	30,829	27
28	**TOTAL General Administration**	(77,230)	(168,964)	111,008	0	0	0	0	0	0	0	0	(135,186)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(77,709)	(293,972)	36,832	0	0	0	0	0	0	0	0	(334,849)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(1,626)	0	61,850	0	0	0	0	0	0	0	0	60,224	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	211,823	0	0	0	0	0	0	0	0	211,823	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(241,550)	0	0	0	0	0	0	0	0	(241,550)	34
35	Rent-Equipment & Vehicles	0	0	(47,890)	0	0	0	0	0	0	0	0	(47,890)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,626)	0	(15,767)	0	0	0	0	0	0	0	0	(17,393)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(150,787)	0	0	0	0	0	0	0	0	(150,787)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	(150,787)	0	0	0	0	0	0	0	0	(150,787)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(79,335)	(293,972)	(129,722)	0	0	0	0	0	0	0	0	(503,029)	45

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					SKOKIE	THERAPY
				PRAIRIE VILLAGE HEALTHCARE CENTER LLC		
					SKOKIE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	CAREPLUS MGMT INC		$	$	1
2	V	19	ADMIN. CONSULTANT FEES	128,000	" "			(128,000)	2
3	V	19	DATA PROCESSING FEES	12,000	" "			(12,000)	3
4	V	21	CLERICAL FEES	75,600	" "			(75,600)	4
5	V				" "				5
6	V	10	M/C,PA CONSULT FEES	150,000	" "			(150,000)	6
7	V	7	SECURITY		" "		237	237	7
8	V	5	ELECTRICITY		" "		452	452	8
9	V	6	REPAIRS		" "		16	16	9
10	V	6	MAINTENANCE SALARIES		" "		4,593	4,593	10
11	V	10	NURSING		" "		17,396	17,396	11
12	V	10a	THERAPY SALARIES		" "		2,298	2,298	12
13	V	17	ADMIN SALARIES		" "		46,636	46,636	13
14	Total			$ 365,600			$ 71,628	$ * (293,972)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	CAREPLUS MGMT INC		$ 2,577	$ 2,577	15
16	V	20	DUES/LICENSES/WANT ADS		" "		2,042	2,042	16
17	V	21	OFFICE SALARIES/EXPENSES		" "		69,920	69,920	17
18	V	23	SEMINARS		" "		837	837	18
19	V	24	TRAVEL		" "		275	275	19
20	V	25	TRANSPORTATION		" "		2,779	2,779	20
21	V	26	INSURANCE		" "		1,749	1,749	21
22	V	27	EMPLOYEE BENEFITS		" "		30,829	30,829	22
23	V	30	SL DEPRECIATION		" "		6,710	6,710	23
24	V	32	INTEREST		" "		19,250	19,250	24
25	V	34	OFFICE RENT		" "		4,116	4,116	25
26	V	35	EQUIP RENT/AUTO LEASE		" "		4,466	4,466	26
27	V								27
28	V								28
29	V	34	RENT	245,666	PRAIRIE VILLAGE HEALTHCARE CENTER LLC			(245,666)	29
30	V	30	SL DEPRECIATION		" "		55,140	55,140	30
31	V	32	INTEREST		" "		192,573	192,573	31
32	V								32
33	V								33
34	V	10a	THERAPY SERVICES	81,740	CAREPLUS REHABILITATIVE SERVICES		7,564	(74,176)	34
35	V	39	ANCILLARY THERAPY	180,283	" "		29,496	(150,787)	35
36	V	35	EQUIPMENT RENT EXPENSE	52,356	" "			(52,356)	36
37	V				" "				37
38	V				" "				38
39	Total			$ 560,045			$ 430,323	$ * (129,722)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CEN # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	32.02	SEE ATTACHED	3.5	5.77	SALARY	10,681	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	32.02	SCHEDULES	3.5	5.77	" "	10,681	17-7	3
4	JAMEE O'BRIEN	REGIONAL DIR.	ADMIN	1.70	" "	3.5	5.77	" "	7,644	17-7	4
5	JOE ZIMMERMAN	CFO	CLERICAL	1.70	" "	3.5	5.77	" "	7,650	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 36,656		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	451,049	13 FACILITIES	$ 26,990	$ 26,990	0	$ 0	1
2	5	ELECTRICITY	" "	565,586	13 FACILITIES	7,834		32,655	452	2
3	6	REPAIRS	" "	565,586	13 FACILITIES	275		32,655	16	3
4	6	MAINTENANCE SALARIES	" "	565,586	13 FACILITIES	79,548	79,548	32,655	4,593	4
5	10	NURSING	" "	565,586	13 FACILITIES	301,295	301,295	32,655	17,396	5
6	10a	THERAPY SALARIES	" "	565,586	13 FACILITIES	39,798	39,798	32,655	2,298	6
7	17	ADMIN SALARIES	" "	565,586	13 FACILITIES	807,745	807,745	32,655	46,636	7
8	19	PROFESSIONAL FEES	" "	565,586	13 FACILITIES	44,637		32,655	2,577	8
9	20	DUES/LICENSES/WANT ADS	" "	565,586	13 FACILITIES	35,362		32,655	2,042	9
10	21	OFFICE SALARIES/EXPENSES	" "	565,586	13 FACILITIES	1,211,025	819,289	32,655	69,920	10
11	23	SEMINARS	" "	565,586	13 FACILITIES	14,490		32,655	837	11
12	24	TRAVEL	" "	565,586	13 FACILITIES	4,769		32,655	275	12
13	25	TRANSPORTATION	" "	565,586	13 FACILITIES	48,136		32,655	2,779	13
14	26	INSURANCE	" "	565,586	13 FACILITIES	30,286		32,655	1,749	14
15	27	EMPLOYEE BENEFITS	" "	565,586	13 FACILITIES	533,964		32,655	30,829	15
16	30	SL DEPRECIATION	" "	565,586	13 FACILITIES	116,219		32,655	6,710	16
17	32	INTEREST	" "	565,586	13 FACILITIES	333,416		32,655	19,250	17
18	34	OFFICE RENT	" "	565,586	13 FACILITIES	71,288		32,655	4,116	18
19	35	EQUIP RENT/AUTO LEASE	" "	565,586	13 FACILITIES	77,344		32,655	4,466	19
20	7	SECURITY	" "	565,586	13 FACILITIES	4,112		32,655	237	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,788,533	$ 2,074,665		$ 217,178	25

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENT # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY: PRAIRIE VILLAGE HEALTHCARE CENTER LLC						$	$			$	1
2	CIB BANK		X	CAPITAL IMPROVEMENTS	$882.75	01/04	37,157	29,487	01/09	PRIME+	2,040	2
3	LOAN COSTS		X	LOAN COSTS		02/01	3,825		W/O BAL		1,657	3
4	CAMBRIDGE		X	MORTGAGE	$16,072.41	11/03	2,830,700	2,792,568	10/33		154,883	4
5	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN	11/03	76,676	73,801			2,556	5
	Working Capital											
6	MIP INSURANCE		X	MORTGAGE INSURANCE							31,437	6
7	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC										19,250	7
8	INSURANCE FINANCING		X	INSUR. FINANCE							1,548	8
9	TOTAL Facility Related				$16,955.16		$ 2,948,358	$ 2,895,856			$ 213,371	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,948,358	$ 2,895,856			$ 213,371	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 31,437 Line # 32-7

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 23,620	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 23,687	2
3. Under or (over) accrual (line 2 minus line 1).		$ 67	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 23,920	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 23,987	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	22,519	8
2000	22,702	9
2001	23,337	10
2002	23,390	11
2003	23,687	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRAIRIE VILLAGE HEALTHCARE CENTER COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0042671

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-17-100-012	NURSING HOME	$ 23,687.26	$ 23,687.26
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 23,687.26	$ 23,687.26

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,028 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1 + BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	RELATED PARTY:PRAIRIE VILLAGE HEALTHCARE CENTER LLC			$	1
2	NURSING HOME: ACRES 8.686		1997	170,000	2
3	TOTALS			$ 170,000	3

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY: PRAIRIE VILLAGE HEALTHCARE CENTER LLC:				$	$		$	$	$	4
5	126		1997		1,114,539	28,577	39	28,577		213,158	5
6											6
7											7
8											8
	Improvement Type**										
9	ELECTRIC PANEL IN BOILER ROOM			1997	1,192	31	39	31		234	9
10	NURSE CALL SYSTEM			1997	17,863	458	39	458		3,396	10
11	40 TON A/C AND GAS LINE			1997	114,953	2,947	39	2,947		21,490	11
12	NEW ROOF			1997	35,981	923	39	923		6,653	12
13	CUBICLE TRACK / PAINTING / HAND & BUMPER RAILS			1997	18,875	484	39	484		3,489	13
14	CEILING TILE / LIGHT FIXTURES / CUBICLE TRACK			1997	44,010	1,128	39	1,128		8,037	14
15	MECHANICAL, PLUMBING, HVAC & ELECTRICAL OVERHAUL			1997	165,706	4,249	39	4,249		30,275	15
16	FLOOR TILE			1997	35,928	921	39	921		6,485	16
17	REMODELLING / PAINTING / WALLCOVERINGS / BUMPER RAIL			1997	52,605	1,349	39	1,349		9,499	17
18	REMODELLING / WALLCOVERINGS / RAILS / WINDOW TREAT			1998	58,466	1,500	39	1,500		10,112	18
19	TILING / FLOORING / DOORS			1998	36,939	948	39	948		6,321	19
20	ELECTRICAL / ELEVATOR / PLUMBING REPAIRS			1998	69,378	1,778	39	1,778		11,777	20
21	GENERATOR			1998	21,049	540	39	540		3,533	21
22	JFK CONTEMPORARY DESIGNS			1999	3,549	91	39	91		459	22
23	CANOPY/BARRIERS/CORNER GUARDS/KICKPLATES			2000	9,164	333	27.5	333		1,436	23
24	SHAYMAN,SALK ARENSON SETTLEMENT / PUMP			2001	54,531	1,983	27.5	1,983		7,486	24
25	CONCRETE WORK / DRYWALL / DOORS			2002	4,490	163	27.5	163		350	25
26	DOOR INSTALLATIONS / 6 VENTILATOR RECEPTACLES			2003	9,733	353	27.5	354	1	533	26
27	CONCRETE SLABS OUTSIDE EXIT DOORS			2003	3,350	223	15	223		335	27
28	REWIRING/COOLER DOOR/BOILER RM MANIFOLD/PIPING			2004	11,341	362	27.5	362		362	28
29											29
30											30
31											31
32											32
33											33
34	RELATED PARTY ALLOCATION - CAREPLUS MGMT					68		68			34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,883,642	$ 49,409		$ 49,410	$ 1	$ 345,420	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 194,824	$ 15,052	$ 14,678	$ (374)	8-15 YRS	$ 101,720	71
72	Current Year Purchases	2,638	1,385	132	(1,253)	10 YRS	132	72
73	Fully Depreciated Assets							73
74	**REL'D PARTY-SL DEPN:CAREPL MGT, 6,642 /PRAIRIE VILL LLC, 6,900		13,542	13,542				74
75	TOTALS	$ 197,462	$ 29,979	$ 28,352	$ (1,627)		$ 101,852	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,251,104	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 79,388	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 77,762	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,626)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 447,272	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A -- RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 68,828 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN	FORD	$ 668.94	$ 6,689	17
18					18
19					19
20					20
21	TOTAL		$ 668.94	$ 6,689	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 75,743	$		$ 75,743	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			23,208			23,208	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			77,665			77,665	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				114,554		114,554	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2 / 39-3				3,666	234		3,900	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					32,914		32,914	13
14	TOTAL			$		$ 180,282	$ 147,702		$ 327,984	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,094)	751,863		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	486,968		5
6	Prepaid Insurance	53,666		6
7	Other Prepaid Expenses	108,876		7
8	Accounts Receivable (owners or related parties)	62,603		8
9	Other(specify): R.E,TAX ESCROW	2,963		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,466,939	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	31,475		15
16	Equipment, at Historical Cost	194,902		16
17	Accumulated Depreciation (book methods)	(193,024)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEPOSITS	4,137		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 37,490	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,504,429	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 626,523	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,375		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,798		31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,920		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 737,616	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO LLC	148,250		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 148,250	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 885,866	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 618,563	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,504,429	$	48

*(See instructions.)

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 970,246	1
2	Restatements (describe):		2
3	POST-CLOSING BAD DEBT ADJUSTMENT	(350,000)	3
4	POST-CLOSING EXPENSES	(15,670)	4
5	ROUNDING	2	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 604,578	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	13,985	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 13,985	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 618,563	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,712,232	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,712,232	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	321	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 321	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	41,700	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 41,700	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,754,253	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	603,475	31
32	Health Care	1,412,388	32
33	General Administration	962,991	33
	B. Capital Expense		
34	Ownership	364,256	34
	C. Ancillary Expense		
35	Special Cost Centers	327,984	35
36	Provider Participation Fee	69,174	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,740,268	40
41	**Income before Income Taxes (line 30 minus line 40)****	13,985	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 13,985	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,022	2,094	$ 44,569	$ 21.28	1
2	Assistant Director of Nursing	351	392	7,483	19.09	2
3	Registered Nurses	5,256	5,353	101,812	19.02	3
4	Licensed Practical Nurses	16,636	17,194	276,482	16.08	4
5	Nurse Aides & Orderlies	41,396	42,266	382,082	9.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,982	6,077	118,076	19.43	7
8	Rehab/Therapy Aides	4,136	4,527	52,736	11.65	8
9	Activity Director	1,877	2,010	16,440	8.18	9
10	Activity Assistants	2,499	2,541	15,244	6.00	10
11	Social Service Workers	2,205	2,362	19,318	8.18	11
12	Dietician					12
13	Food Service Supervisor	2,178	2,356	29,691	12.60	13
14	Head Cook	6,381	6,530	47,733	7.31	14
15	Cook Helpers/Assistants	7,231	7,457	47,651	6.39	15
16	Dishwashers					16
17	Maintenance Workers	3,080	3,105	28,237	9.09	17
18	Housekeepers	12,283	12,498	79,393	6.35	18
19	Laundry	5,242	5,498	36,015	6.55	19
20	Administrator	1,952	2,099	53,617	25.54	20
21	Assistant Administrator	1,930	2,101	43,763	20.83	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,943	5,286	76,959	14.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,032	2,092	17,804	8.51	31
32	Other Health Care(specify)					32
33	Other(specify) MARKETING	1,790	1,854	36,224	19.54	33
34	TOTAL (lines 1 - 33)	131,402	135,692	$ 1,531,329 *	$ 11.29	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 8,355	1-3	35
36	Medical Director	O	27,400	9-3	36
37	Medical Records Consultant	N	669	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	709	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) PSYCHO-SICIAL	S	4,108	10-3	46
47	PSYCHIATRIC		5,000	10-3	47
48	M/C & PA CONSULTANT		150,000	10-3	48
49	TOTAL (lines 35 - 48)		$ 207,041		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DIANNA BLACKKETTER	ADMIN	0	$ 53,617
PAMELA BROWN	ASST ADMIN	0	43,763
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,380

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		303,273
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 303,273

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 37,170
Unemployment Compensation Insurance		25,964
FICA Taxes		116,269
Employee Health Insurance		21,660
Employee Meals		11,749
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		2,342
EMPLOYEE PHYSICAL EXAMS		205
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 215,359

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,397
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	22,668
TRUST/FRANCHISE/CONTRIB/ETC	400
LICENSES & PERMITS	1,055
DUES & SUBSCRIPTIONS	211
MGMT CO ALLOCATION	2,042
TRUST/FRANCHISE/CONTRIB/ETC	(400)
Less: Public Relations Expense	(0)
Non-allowable advertising	(22,668)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,705

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL & LODGING	589
MGMT CO ALLOCATION	275
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 864

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PRAIRIE VILLAGE HEALTHCARE CENTER # 0042671 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **729** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **69,174**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,749** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees